Child Health and Disability Prevention (CHDP) Program
FACILITY REVIEW TOOL SCORING INSTRUCTIONS

General Guidelines for Facility Site Review

- All sites, including mobile vans, satellite centers, and school-based clinics, must be reviewed using the CHDP Facility Review Tool (DHS 4493) in conjunction with the CHDP Medical Record Review Tool (DHS 4492) during an on-site visit to a Provider.

- Each facility operated by a Provider must meet all critical elements (CE) and have a passing score of greater than 84 percent to be enrolled in the CHDP Program. The critical elements are: Airway Management; Anaphylactic Reaction Medication Administration; Current Professional License; Participation in the Vaccines for Children (VFC) Program, including all criteria identified in the Pharmaceutical Services Survey Criteria section, and meet all the criteria in Preventive Services Survey Criteria section. CEs are identified with shaded rows and "CE" under the weight (Wt.) column.

- Abbreviated Facility Reviews of CHDP Providers during application for enrollment or during periodic reviews of enrolled Providers may be conducted when the local CHDP Program has a copy or summary of scores and conclusions from a survey conducted within the preceding 12 months by the Medi-Cal Managed Care Division or plan. An abbreviated facility review is a review of the five CEs and all of the criteria within the CE in the DHS 4493.

- Providers currently enrolled in the CHDP Program must meet all CEs and have a passing score of greater than 69 percent among the other criteria in the review. A score from 70 through 84 percent requires joint efforts between the local CHDP Program and the Provider for the correction of deficiencies and achievement of program standards within three months.

Directions for Scoring

A total of 92 items are scored. Every criterion is weighted either one or two points, except for the CE.

- Score full-weighted points (1 or 2 as designated) for each criterion that is met in the weight column. Do not score partial points for any criterion.

- Score zero points if criterion is not met.

- Not applicable (N/A) applies to any criterion that does not apply to the facility being reviewed. Score N/A with the full-weighted points (1 or 2 as designated) for that criterion.

- Add the subtotal scores and record the total points for each section.

- Add the total points for each section to determine the points in the total review score.

- Score the five Critical Elements (CE) as stand alone criteria. All CEs must be met by new Providers entering the program. Current Providers undergoing periodic review, may be given conditional status as stipulated in a–e below with the understanding that correction is needed immediately.

  a. Airway management equipment must all be present.

  b. Anaphylactic reaction medication as stipulated in the criteria must be present.

  c. Current professional license(s) are required and means the Provider can not be newly enrolled in the CHDP Program. If the Provider is enrolled in CHDP, continuing enrollment at the time of a periodic review may be conditional if any of the Providers do not have a current license but can show proof of having submitted their license renewals before the expiration date.

  d. VFC Provider status is required as well as the 15 criteria under this heading in order to provide appropriate vaccinations, documentation, and education/guidance. A new Provider can not be enrolled nor a current Provider be recertified if not participating in the VFC Program.

  e. Preventive Services, as defined, must be met. A new Provider can not be enrolled in the CHDP Program if they fail to meet any of these criteria. At the time of recertification, the local CHDP Program determines whether the Provider will be assigned conditional status due to the failure to meet any one criterion in the Preventive Services section. Status will be dependent on satisfactory compliance with all other criteria in the Facility Review Tool .

- Calculate the percent score by dividing the ***review score points by the total possible points.*** Multiply by 100 to obtain the percentage. For example:

  (80 Review Score Points) divided by (92 total possible points) x 100 = 87 percent

- Round percentages to the next smaller percentage for .1–.5, or to the next larger percentage for .6–.9.

- Determine the degree of successful completion by the Provider for the facility review using the following thresholds.

Thresholds

- If Critical Elements (CE) not met:

Airway Management not met:	New Provider	= FAIL
	Periodic Review	= FAIL
Anaphylactic Medication not met:	New Provider	= FAIL
	Periodic Review	= FAIL
Current Professional License not met:	New Provider	= FAIL
	Periodic Review	= CONDITIONAL
Vaccines for Children (VFC) Provider and all criteria identified as CE in the Pharmaceutical Services Survey Criteria Section not met:	New Provider	= FAIL
	Periodic Review	= FAIL
Preventive Services not met:	New Provider	= FAIL
	Periodic Review	= CONDITIONAL—dependent on the total survey

- 85% through 100% = FULL APPROVAL
- 70% through 84% = CONDITIONAL APPROVAL
- Less than 70% = NOT APPROVED

Remember to complete the Facility Review Scoring Summary Sheet (DHS 4494) and attach it to the Facility Review Tool face sheet.

Criteria	Facility Reviewer Guidelines
Facility Review Tool **Face Page**	**Review date:** Complete by entering the date or dates of review. **Provider name and address:** Enter Provider name and the address of the office location for the facility being reviewed. **Contact person/title:** Enter the first and last name and the title of the person with whom the visit was arranged. This should be the person designated by the Provider as the primary contact. **Reviewer/title:** Enter first and last names and license title of the reviewer(s) conducting the facility review. **Last CHDP review date and results**: Enter the date that a prior review was completed and the percent compliance. **Phone:** Enter the primary telephone number of the office. **Fax:** Enter the fax number of the office. **Fire clearance:** Enter yes or no for evidence of current fire clearance. **Clinicians on-site:** Enter first and last name(s) and license title (MD, PA, NP) of CHDP physician(s), physician assistants, nurse practitioners performing CHDP health assessment(s) at the site. **CHDP Provider category:** Place a mark in the space that designates for which status the Provider is making application. This may be retrieved from the Provider application. **Visit purpose:** Indicate the purpose for this site visit to the facility. Check only one of the following: • *Initial full scope:* Visit to a new Provider, not previously enrolled. • *Periodic full scope:* Provider enrolled and in the process of three-year recertification review. • *Monitoring:* Provider is in the process of making corrections to identified problem areas. • *Follow-up:* Provider had established completion of corrections and visit has been arranged to confirm their implementation. • *Focused review:* Previous site visit observed and reported problem areas, or potential problems were identified through review of documents, or CHDP received a client complaint. • *Education/technical assistance:* Provider is already enrolled but is receiving a visit secondary to changes in staff, other CHDP Program policy. **History of other DHS certification(s):** Identify other certifications that have been completed in the last year by inserting the date the certification visit occurred. **Provider(s) at the site:** Identify the array of Provider types working at the site/facility and their specialization. Complete the space with the number of known Providers within that specialty or area of practice. **Office/clinic type:** Indicate the type of Provider for this CHDP Provider that corresponds with the range of Provider types in CHDP. Select the type that pertains to this site. **Total score:** Enter total score. The total score is the cumulative total among all areas. **Percent compliance:** Divide the total score by the total number of points possible and enter the percent in the space provided. **Approval status:** Identify the approval status using the criteria listed in the Facility Review Tool Instructions and check one.

Child Health and Disability Prevention (CHDP) Program
FACILITY REVIEW TOOL

Review date		Last CHDP review date and results		
Provider name		Telephone number ( )		Fax number ( )
Provider address (number, street)	City	State	ZIP code	Fire clearance current ☐ Yes ☐ No
Contact person	Title	Clinicians on-site		
Reviewer	Title			
Reviewer	Title	CHDP Provider category: ☐ Comprehensive ☐ Health assessment only		

Visit Purpose	History of Other DHS Certification(s)	Provider(s) at Site	Office/Clinic Type
(Check only one.)	Date: _____	(Check all that apply.)	(Check only one.)
☐ Initial Full Scope	☐ CHDP	☐ Family Practice	☐ County Hospital Outpatient Clinic
☐ Periodic Full Scope	☐ Comprehensive Perinatal Services Program	☐ Pediatrics	☐ Community Hospital Outpatient Clinic
☐ Monitoring	☐ DHS Licensing and Certification	☐ General Practice	☐ Community Health Clinic
☐ Follow-up	☐ Medi-Cal Managed Care Division	☐ Internal Medicine	☐ Family Nurse Practitioner
☐ Focused Review	☐ Childhood Lead Program	☐ OB/GYN	☐ FQHC/Rural Health Clinic
☐ Education/Techinical Assistance	☐ Vaccines for Children	☐ Specialist	☐ Health Department Clinic
☐ Other _____		☐ Nonphysician Medical Practitioner (type: _____)	☐ Indian Health Clinic
		☐ Other (type: _____)	☐ Nonhospital-based Outpatient Clinic
			☐ Pediatric Nurse Practitioner
			☐ Physician Solo Practitioner
			☐ Physician Group Practice
			☐ Other (type: _____)

Total score: _____ Percent (%) compliance: _____%

Approval status: ☐ Full approval (85% through 100%) (required for new applicants) ☐ Conditional approval (70 through 84%) ☐ Not approved (less than 70%)

Criteria	Facility Reviewer Guidelines
Site Access/Safety Survey Criteria **A. Site is accessible and useable by individuals with physical disabilities.**	Sites must have the following safety accommodations for persons with physical disabilities: **Exit doors:** Includes all doors required for access, circulation, and use of the building and facilities, such as primary entrances and passageway doors. Width of exit doorways (at least 32-inches) allows for passage clearance of a wheelchair. Furniture and other items do not obstruct exit doorways or interfere with door swing pathway. **Elevators:** If a site has no passenger elevator, a freight elevator may be used to achieve program accessibility if upgraded so as to be usable by passengers generally and if passageways leading to and from the elevator are well-lit, neat, and clean. **Clear Floor Space:** Clear space in waiting/exam areas is sufficient to accommodate a single, stationary adult wheelchair and occupant. **Wheel Chair Access to Sanitary Facilities:** Restroom and hand-washing facilities are accessible to able-bodied and handicapped persons. A restroom that is wheelchair accessible allows sufficient space in toilet area for a wheelchair to enter and permits the door to close. If there are no wheelchair accessible restrooms within the site, reasonable alternative accommodations must be made available. Alternatives may include: grab bars located behind and/or along the sides of toilet with assistance provided by site personnel as needed, use of urinal, bedpan, or bedside commode in private area, wheelchair accessible restroom facilities located in a nearby office and/or shared within a building. For wheelchair-bound persons to safely use a lavatory sink for hand-washing, sufficient space underneath the sink is needed for knee clearance. A reasonable alternative may include, but is not limited to, hand-washing items provided when needed by site staff. **Note:** A clear space of at least 30-inches by 48-inches is needed to accommodate an adult wheelchair and occupant. A minimum clear space of 60-inches diameter or square area is needed to turn a wheelchair. Specific measurements are provided for *reference only*. Reviewers are *NOT REQUIRED* to measure site areas.

1. Access/Safety

Site Access/Safety Survey Criteria	Wt..	Yes	No	N/A	Site Score
A. Site is accessible and useable by individuals with physical disabilities.[1]					
Sites must have the following safety accommodations for persons with physical disabilities:					
1. Exit doorway openings allow for clear passage of a person in a wheelchair.	1				
2. Accessible passenger elevator or reasonable alternative for multi-level floor accommodations.	1				
3. Clear floor space for wheelchair in waiting area and exam room.	1				
4. Wheelchair accessible restroom facilities or reasonable alternative.	1				
5. Wheelchair accessible hand washing facilities or reasonable alternative.	1				
Subtotal:					

Comments: Write comments for all zero (0) scores.

[1] 3 CCR §504; 24 CCR; 28 CFR; 29 CFR (OSHA); 42 USC (American Disabilities Act of 1990)

Criteria	Facility Reviewer Guidelines
Site Access/Safety Survey Criteria **B. Site environment is safe for all clients, personnel, and visitors.**	The following safety and fire precautions are evidenced on-site: **Exits**: Exit doorways are unobstructed and clearly marked by a readily visible "Exit" sign. **Access aisle:** Accessible pedestrian paths of travel (ramps, corridors, walkways, lobbies, elevators, etc.) between elements (seats, tables, displays, equipment, parking spaces, etc.) shall provide a clear circulation path. Means of egress (escape routes) shall be maintained free of all obstructions or impediments to full instant use of the path of travel in case of fire or other emergency. Building escape routes provide an accessible, unobstructed path of travel for pedestrians and/or wheelchair users at all times when the site is occupied. Cords (including taped cords) or other items are not placed on or across walkway areas. **Fire fighting/protection equipment:** There is fire fighting/protection equipment in an accessible location on-site at all times. An accessible location is one that is reachable by personnel standing on the floor, or other permanent working area, without the need to locate/retrieve stepstool, ladder, or other assistive devices. At least one of the following types of fire safety equipment is on-site: 1. Smoke detector with intact, working batteries. 2. Fire alarm device with code and reporting instructions posted conspicuously at phones and employee entrances. 3. Automatic sprinkler system with sufficient clearance (10 inches) between sprinkler heads and stored materials. 4. Fire extinguisher in an accessible location that displays readiness indicators or has an attached current dated inspection tag. **Note:** If there are no sprinklers, a smoke alarm and fire extinguisher are required. **Note:** Sites must meet city, county, and state fire safety and prevention ordinances. The minimum clear passage needed for a single wheelchair is 36 inches along an accessible route, but may be reduced to a minimum of 32 inches at a doorway. Reviewers are not required to measure building areas.
Site Access/Safety Survey Criteria **C. Emergency medical equipment available on-site is appropriate to the practice and client population.**	**Emergency care:** During business hours, Providers shall be prepared to provide emergency services for the management of emergency medical conditions that occur on-site until the emergent situation is stabilized and/or treatment is initiated by the local 911 Emergency Medical Service (EMS) system. An "emergency medical condition" is a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: (1) placing the health of the individual (or unborn child of a pregnant woman) in serious jeopardy, (2) serious impairment to bodily functions, and (3) serious dysfunction of any bodily organ or part. "Emergency services" means those services required for alleviation of severe pain, or immediate diagnosis and treatment of unforeseen medical conditions, which, if not immediately diagnosed and treated, would lead to disability or death. Emergency equipment and education, appropriate to patient population and conditions treated, are available on-site and accessible. An accessible location is one that is reachable by personnel standing on the floor, or other permanent working area, without the need to locate/retrieve stepstool, ladder, or other assistive devices. **Emergency medical equipment:** Minimum emergency equipment is available on-site to: (1) establish and maintain a patent/open airway, and (2) manage anaphylactic reaction. A site's proximity to emergency care facilities may be considered when evaluating site-specific, medical emergency procedures. Site must have a clearly established system for providing basic emergency care on-site until the local Emergency Medical System has taken over care/treatment. **Airway management:** Minimum airway control equipment includes a wall oxygen delivery system or portable oxygen tank, oropharyngeal airways, nasal cannulas, ambu bags, and pocket masks. Various sizes of airway devices are on-site that is appropriate to client population within the practice. Portable oxygen tanks are maintained at least ¾ full. There is a method/system in place for oxygen tank replacement. If oxygen tanks are less than ¾ full at time of site visit, site has a back-up method for supplying oxygen if needed and a scheduled plan for tank replacement. Oxygen tubing need not be connected to oxygen tank, but must be kept in close proximity to tank. **Anaphylactic reaction management:** Severe allergic reaction can cause urticaria (hives), hypotension, bronchospasm, wheezing, and pulmonary edema. Minimum equipment includes Epinephrine 1:1,000 and 1:10,000 (subcutaneous use), Benadryl oral and IM, tuberculin syringes, Betadine solution, alcohol wipes. There is a current medication administration reference (e.g., medication dosage chart) available for readily identifying correct medication dosages (e.g., adult, pediatric, infant, etc.). A process is in place to restock all items used in an emergency. **Local poison control number:** The number is posted and visible for personnel. **Note:** If there is any emergency "crash" cart/kit on-site, contents are appropriately sealed and within the expiration dates posted on label/seal. Site personnel are trained and can demonstrate knowledge and correct use of all emergency medical equipment kept on-site.
Site Access/Safety Survey Criteria **D. Accessible by public transportation.**	Federal regulations mandate that each state Medicaid agency specify in its state plan that it will ensure necessary transportation for clients to and from Providers and the methods the agency will use to meet this requirement (42 Code of Federal Regulations (CFR) 431.53). The Medicaid agency is further directed to offer and provide clients of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services with necessary assistance with transportation if requested (42 CFR 441.62). Adequate transportation can result in fewer missed appointments, thus making physicians and other health care Providers more willing to participate in EPSDT/CHDP. The client's physical, mental, or medical condition often dictates the appropriate mode of transportation. It is important to note where the Provider's office is located and what public transportation is available to the Provider site. In the comments area, write the kinds of public transportation by which the Provider site is accessible, e.g., bus, train, shuttle, etc. Give one point for access to the Provider site if other than by personal vehicle.

Site Access/Safety Survey Criteria	Wt.	Yes	No	N/A	Site Score
B. Site environment is safe for all clients, personnel, and visitors.[2]					
The following safety and fire precautions are evidenced on-site:					
1. Exit doors and aisles are unobstructed and egress (escape) accessible.	1				
2. At least one type of fire fighting/protection equipment is accessible at all times.	1				
C. Emergency health care services are available and accessible.[3]					
Emergency medical equipment appropriate to practice/client population is available on-site:					
1. **Airway management**: oxygen delivery system, oral airways, nasal cannulas, ambu bags, pocket masks, pediatric airways (infant/child), mask sizes 0–4 and meet AAP standards for drugs and equipment.	CE				
2. **Anaphylactic reaction medication administration**: Epinephrine 1:1,000 (injectable subcutaneous), also for pediatric sites Epinephrine 1:10,000 (injectable), Benadryl 25 mg (oral), Benadryl 50 mg/ml IM, tuberculin syringes, Betadine solution, alcohol wipes.	CE				
3. Medication dosage chart (or other method for determining dosage) is kept with emergency medications.	2				
4. Emergency equipment is stored together in easily accessible location.	1				
5. There is documented evidence (e.g., log) that emergency equipment/supplies are checked for expiration and operating status at least monthly.	1				
6. There is a process to replace/restock emergency equipment immediately after use.	1				
7. Local poison control center number is posted.	1				
D. Site is accessible by public transportation.	1				
Subtotal:					
Comments: Write comments for all zero (0) scores. **Section Total:**					

[2] 8 CCR §3220, 10 CCR §1300.80, 22 CCR §53230, 24 CCR, 29 CFR §1910.301, §1926.34
[3] 10 CCR §1300.67, 22 CCR §51056, §53216, 42 USC §139.5(d)

Criteria	Facility Reviewer Guidelines		
Site Personnel Survey Criteria **A. Professional personnel have current California licenses and certifications.**	**Health Care Professional**	**License/Certification**	**Issuing Agency**
	Certified Nurse Midwife (CNM)	RN License Nurse-midwife License/Certificate	California Board of Registered Nursing Medical Board of California
	Certified Radiological Technologist (CRT)	CRT Certificate Operator or Operator Supervisor	California Department of Health Services (Radiological Branch)
	Doctor of Osteopathy (DO)	Physician and Surgeon License	Osteopathic Medical Board of California
	Licensed Vocational Nurse (LVN)	LVN License	California Board of Vocational Nursing and Psychiatric Technicians
	Nurse Practitioner (NP)	RN License and NP License NP Furnishing Certificate (as applicable)	California Board of Registered Nursing California Board of Registered Nursing
	Pharmacist (Pharm. D.)	License	California State Board of Pharmacy
	Physician (MD)	Physician and Surgeon License	Medical Board of California
	Physicians' Assistant (PA)	PA License	Physician Assistant Examining Committee/Medical Board of California
	Radiological Technician	Limited Permit Operator or Operator Supervisor	California Department of Health Services (Radiological Branch)
	Registered Dietitian (RD)	RD Registration Card	Commission on Dietetic Registration
	Registered Nurse (RN)	RN License	California Board of Registered Nursing
	Note: All health care professional California licenses and certifications must be current and issued from the appropriate agency. The above listed health care professional licenses and certificates are issued for practice in California. Any license/certification that has been approved during the current re/credentialing process need not be rechecked during the site review. Any licenses or certifications not included in the re/credentialing process must be checked for current status as part of the site review process. Although staff model sites or sites with centralized personnel departments are not required to keep documents or copies on-site for reviewers, copies of documents and/or lists of currently certified or credentialed personnel must be readily available, if needed. If a radiological technician has only an operator license, a supervisor must be identified and posted.		
Site Personnel Survey Criteria **B. Health care practitioners are properly identified.**	A health care practitioner shall disclose, while working, his or her name and practitioner's license status, as granted by the State of California, on a name tag at least 18-point type. "Health care practitioner" means any person who engages in acts that are the subject of licensure or regulation under the California Business and Professional Code. A health care practitioner in a practice or an office, whose license is prominently displayed, may opt not to wear a name tag. In the interest of public safety and consumer awareness, it shall be unlawful for any person to use the title "nurse" in reference to himself or herself, in any capacity, except for an individual who is a RN or a LVN. **Note:** If a health care practitioner or a licensed clinical social worker is working in a psychiatric setting or in a setting that is not licensed by the State, the employing entity or agency shall have the discretion to make an exception from the name tag requirement for the individual safety or therapeutic concerns.		

2. Personnel

Site Personnel Survey Criteria	Wt.	Yes	No	N/A	Site Score
A. Professional Personnel have current California Licenses and Certifications.[4]					
1. All required professional licenses and certifications are current.	CE				
B. Health care personnel are properly identified.[5]					
1. All health care personnel wear identification badges/tags printed with name and title.	1				
Subtotal:					

Comments: Write comments for all zero (0) scores.

[4] California Business and Professional Code §2050, §2585, §2725, §2746, §2834, §3500, §4110
[5] California Business and Professional Code §680, AB 1439

Site Personnel Survey Criteria **C. All staff members are qualified and trained for assigned responsibilities.**	**Medications:** Unlicensed staff (e.g., medical assistant) has evidence of appropriate training and supervision in all medication administration methods performed within their scope of work. Administration of medications by a medical assistant (MA) means the direct application of premeasured medications orally, sublingually, topically, vaginally or rectally, by providing a single dose to a patient for immediate self-administration, by inhalation or by simple injection. In every instance, prior to administration of medication by the MA, a licensed physician or podiatrist, or another person authorized by law to do so shall verify the correct medication and dosage. The prelabeled medication container must be shown to the licensed person prior to administration. The MA may administer injections or scheduled drugs, including narcotic medications, ***only*** if the dosage is verified and the injection is intradermal, subcutaneous, or intramuscular. All medications administered by an MA must be specifically authorized by the supervising physician. Specific authorization means a specific written order or standing order prepared by the supervising physician. MAs may not place an intravenous (IV) needle, start or disconnect the IV infusion tube, administer medications or injections into an IV line, or administer anesthesia. **Medical equipment:** All personnel are appropriately trained in the proper use of all medical equipment they are expected to operate in their scope of work. For any medical equipment kept on-site, there are personnel on-site who are qualified and/or trained to use equipment properly. (For example, if there is an emergency "crash" cart/kit on-site, personnel on-site are qualified and properly trained in the correct use of the equipment.) Reviewers may interview site personnel regarding the appropriate use of equipment and/or request demonstrated use of equipment, as appropriate. **Unlicensed personnel:** MAs are unlicensed health personnel, at least 18 years of age, who perform basic administrative, clerical, and noninvasive routine technical supportive services under the supervision of a licensed physician, surgeon, or podiatrist in a medical office or clinic setting. Supervision means that a licensed physician must be physically present in the treatment facility during the performance of authorized procedures by the MA. In order to administer medications by intramuscular, subcutaneous, and intradermal injection, to perform skin tests or venipuncture for the purpose of withdrawing blood, the MA must have completed at least the minimum amount of training hours established in Title 16, Section 1366.1. Training may be administered under a licensed physician; or under an RN, LVN, PA, or other qualified MA acting under the direction of a licensed physician. The supervising physician is responsible for determining the training content and ascertaining proficiency of the MA. MA training documentation maintained on-site must include the following: ● Diploma or certification from an accredited training program/school, ***or*** ● Letter/statement from the current supervising physician that certifies in writing: date, location, content, and duration of training, demonstrated proficiency to perform current assigned scope of work, and signature. **Office personnel, scope of work, and training for vision and hearing screening:** Identified and defined through procedures and documentation of personnel in attendance at state trainings for vision screening and audiometric screening. **Nonphysician Medical Practitioners (NMP):** **Nurse Practitioners (NP):** NPs are prepared through education and experience to provide primary care and to perform advanced procedures. The extent of required supervision must be specified in the Standardized Procedures. **Physician Assistants (PA):** Every PA is required to have the following documents: Delegation of Services Agreement: This written agreement between supervising physician and PA defining specific procedures identified in practice protocols or specifically authorized by the supervising physician must be dated and signed by both individuals. An original or copy must be readily accessible at all practice sites in which the PA works. There is no established time period for renewing the Agreement, but it is expected that the Agreement will be revised, dated, and signed whenever any changes occur. Failure to maintain a Delegation of Services Agreement is a violation of the Physician Assistant Regulations and is grounds for disciplinary action by the Medical Board of California against a PA's licensure. Approved Supervising Physician's Responsibility for Supervision of Physician Assistants: This written document, signed by the supervising physician, defines supervision responsibilities and methods required by Title 16, Section 1399.545, of the Physician Assistant Regulations. The following procedures must be identified: Transport and back-up procedures for immediate care of patients in need of emergency care that is beyond the PA's scope of practice when the supervising physician is not on the premises. One or more of the following methods for performing medical record review by the supervising physician: ● Examination of patient by supervising physician the same day as care is given by the PA; ● Review/audit and countersign all medical records of the PA within 30 days of the encounter; ● Review/audit and countersign medical records of at least 10 percent of patients managed by the PA under any protocols adopted by the supervising MD and PA; ● Other methods approved in advance by the Physicians Assistant Examining Committee. Responsibility to review, countersign, and date within seven days the medical record of any patient cared for by a PA for whom the physician's prescription was transmitted or carried out. Responsibility to review, countersign, and date medical records of any patient cared for by a PA operating under interim approval within seven days if physician was on the premises at the time, and within 48 hours if physician was not on the premises. Responsibility of the PA to enter the name of his/her approved supervising physician who is responsible for the patient on the medical record, chart, or written order each time the PA provides care and enters his/her name, signature, initials, or computer code. When the PA transmits an oral order, the supervising physician's name must also be stated.

Criteria	Facility Reviewer Guidelines
Site Personnel Survey Criteria **C. All staff members are qualified and trained for assigned responsibilities (continued).**	**Supervising physician:** "Supervising physician" means a physician and surgeon licensed by the Medical Board or by the Osteopathic Medical Board of California who supervises one or more PAs, possesses a current valid license to practice medicine, and is not currently on disciplinary probation for improper use of a PA. Physicians must comply with all current and/or revised requirements established by the Medical Board of California for supervising PAs. **Supervision of Nonphysician Medical Practitioners (NMP):** "Supervision" means that a licensed physician and surgeon oversees the activities of, and accepts responsibility for, the medical services rendered by a PA. The Supervising Physician holds ultimate responsibility for the practice of each supervised NMP. The ratio of physician supervising to number of NMPs is not to exceed established ratios in any combination of the following: 1:4 Nurse Practitioners 1:2 Physician Assistants The designated supervising or back-up physician is to be available in person or by electronic communication at all times when a NMP is caring for clients. **Note:** Personnel on-site must be qualified for their responsibilities and adequately trained for their scope of work. Site staff should have a general understanding of the systems/processes in place, appropriate supervision, and knowledge of the available sources of information on-site. **Note:** Standardized procedures legally define the expanded scope of nursing practice that overlaps the practice of medicine. CNMs and NPs operate under written standardized procedures that are collaboratively developed and approved by the supervising physician, the NP, and administration within the organized health care facility/system in which standardized procedures will be used. Standardized procedures should identify the furnishing of drugs or devices, extent of physician or surgeon supervision, method of periodic review of competence, including peer review, and review of provisions in the standardized procedures. Standardized procedures shall undergo periodic review, with signed, dated revisions completed at each change in scope of work.

Site Personnel Survey Criteria	Wt.	Yes	No	N/A	Site Score
C. All staff members are qualified and trained for assigned responsibilities.[6]					
1. ***Only*** qualified/trained personnel retrieve, prepare, or administer medications.	1				
2. ***Only*** qualified/trained personnel operate medical equipment.	1				
3. Evidence of training or attendance at state training in audiometric testing is documented.	1				
4. Evidence of vision training is documented.	1				
5. Scope of practice for nonphysician medical practitioner is clearly defined.[7]	1				
6. Nonphysician medical practitioners are supervised according to established standards.[8]	2				
Subtotal:					

Comments: Write comments for all zero (0) scores.

[6] California Business and Professional Code §2069, 16 CCR §1366
[7] 16 CCR (7) (14); 16 CCR §1399.540, §1399.545
[8] 22 CCR §51240, §51241

Site Personnel Survey Criteria **D. Staff receives appropriate training for safety and client rights.**	**Infection control, universal precautions, and bloodborne pathogens:** Site personnel shall treat all blood and other potentially infectious materials (OPIM) as if they are infectious. Site personnel at healthcare facilities, physician's offices, and outpatient medical clinics who are reasonably anticipated to have eye, skin, mucous membranes, and potential exposure to blood and/or OPIM shall receive training as required by the Bloodborne Pathogens Standard, Title 8, CCR, Section 51193. Training must occur ***prior*** to initial exposure to potentially infectious and/or biohazardous materials with retraining sessions held at least annually. Training content shall be appropriate to personnel on-site. Training must minimally include the following topics: • Universal/standard precautions • Accessible copy of Bloodborne Pathogens Standard • Modes of transmitting bloodborne pathogens • Recognition of activities with exposure element • Hepatitis B vaccination protocol and requirements • Postexposure reporting/evaluation/follow-up procedures • Site's written Bloodborne Pathogen Exposure Plan • Use of personal protective equipment • Work practice controls/exposure prevention • Epidemiology/symptoms of HBV and HIV • Handling and labeling of biohazardous waste(s) • Explanation of emergency procedures • Decontamination of equipment/work areas • Opportunity for discussion/questions **Emergency actions:** Personnel have been trained in procedures/action plan to be carried out on-site in case of medical and nonmedical emergencies. Site staff is able to describe the following: (1) site-specific procedure for handling medical emergencies, including infant and child CPR, until the individual is under the care of local emergency medical services (EMS), (2) site-specific procedure for handling nonmedical emergencies, such as fires, workplace violence incidents, etc. Staff must be able to locate information regarding the handling of medical and nonmedical emergencies on-site, and can explain how to use information. **Abuse reporting:** Health practitioners (physicians, surgeons, licensed nurses, licensed social workers, paramedics, etc.) in a health facility (clinic, physician's office, public health clinic, etc.) are legally mandated reporters of known or reasonably suspected cases of child abuse, elder abuse, and domestic violence. Legally mandated reporters must make telephone and written reports according to timeliness standards established by the designated local law enforcement agencies in each county. "Reasonably suspects" means having objectively reasonable suspicion based upon facts that could cause a reasonable person in a like position, drawing when appropriate on his or her training and experience, to suspect abuse (California Penal Code 11162.8). Failure to report by legally mandated reporters can result in criminal or civil prosecutions, punishable by monetary fines and/or county jail confinement. Any person entering employment which makes him/her a mandated reporter must sign a statement, provided and retained by the employer, that the employee has knowledge of the child abuse reporting law and will comply with its provision (California Penal Code 11166.5). Site personnel must have specific knowledge of local reporting requirements, agencies, methodologies, and/or where to locate the information when needed. **Note:** Personnel at Provider sites must have basic knowledge about infection control, the handling of medical emergencies, and fire prevention and safety. Personnel at Provider sites must know ***where*** to locate information ***on-site*** about infection control, the Bloodborne Pathogens Exposure Plan, handling of medical/nonmedical emergencies and fire safety, and ***how to use*** the information. Acceptable evidence of training may include: in-service training, orientation of new staff, fire drills, training attendance records, educational curriculum/lesson plans, etc. Training documentation must contain the employee's name, job titles, training date(s), type of training, contents of training session, and names/qualifications of trainers. Records must be kept for three years. Site personnel have received training/information about client rights. Acceptable evidence of training may include in-service training, orientation of new staff, training attendance records, educational curriculum/lesson plans, etc. Staff is able to locate client rights information on-site, and can explain how to use information.

Site Personnel Survey Criteria	Wt.	Yes	No	N/A	Site Score
D. Staff receives appropriate training for safety and client rights.[9, 10]					
There is documented evidence that on-duty, on-site staff has received training in the following:					
1. Infection control/universal precautions	1				
2. Bloodborne pathogens exposure prevention	1				
3. Biohazardous waste handling	1				
4. Pediatric emergency medical procedures	1				
5. Emergency nonmedical procedures (e.g., workplace violence, abusive clients)	1				
6. Child/elder/domestic violence abuse and mandated reporting	1				
7. Fire prevention/safety	1				
8. Infant and child CPR	1				
9. The written emergency plan	1				
10. Client confidentiality	1				
11. Release of information	1				
12. Sensitive services/minors' rights	1				
13 Consent to treat, participate in referral process, procedures, and resources	1				
Subtotal:					

Comments: Write comments for all zero (0) scores.

Section Total:					

[9] 8 CCR §5193, California Health and Safety Code §117600, California Penal Code §11162, §11168, 29 CFR §1910, §1926
[10] 22 CCR §51009, §51014, §51305, §53452, §53858, CCR §1300.68

Criteria	Facility Reviewer Guidelines
Office Management Survey Criteria **A. Physician coverage is available.**	Current clinic office hours are posted within the office or readily available upon request. When a physician is not on-site during regular office hours, site staff is able to contact the physician at all times by telephone, cell phone, pager, etc. Personnel is knowledgeable about scheduled physician coverage during office hours and for after-hours urgent and emergent physician coverage 24 hours per day, 7 days per week, to provide follow-up care. Current resource information is available to site personnel. **Note:** This is a requirement for Comprehensive Care entities/examiners only. Health Assessment Only entities/examiners must refer clients to medical and dental homes that provide this coverage. **Note:** The review of office management evaluates whether effective clinic office systems are in place and whether site personnel appropriately use established site-specific procedures. The primary objective of effective clinic office management is to support and enhance the provision of appropriate, coordinated health care services.
B. Sufficient health care personnel provide timely, appropriate health care services.	Telephone triage is the system for managing telephone callers during ***and*** after office hours. In addition to the physician, only appropriately licensed medical personnel such as an NP, RN, or PA shall handle emergency, urgent, and medical advice/triage telephone calls. **Note:** The Board of Vocational Nurse and Psychiatric Technician Examiners has determined that the Licensed Vocational Nurse Practice Act does not permit the LVN to perform triage independently (MCPB Letter 92-15). LVNs may perform that part of the triage process that includes observation and data collection relative to basic physical assessment. LVNs may not perform that part of the triage process that includes independent evaluation, interpretation of data, and determination of treatment priorities and levels of care. Unlicensed personnel, such as MAs, may provide patient information and instructions only as authorized by the physician (Title 16, §1366(b)).

3. Office Management

Office Management Survey Criteria	Wt.	Yes	No	N/A	Site Score
A. Physician coverage is available.[11]					
Type of CHDP category: ☐ Comprehensive Care Provider ☐ Health Assessment Only					
The following are maintained current on-site:					
1. Provider office hour schedules are available to staff.	1				
2. Arrangement/schedule for after-hours, on-call, supervisory back-up physician coverage is available to staff.	1				
3. Contact information for off-site physician(s) is available at all times during office hours.	1				
4. After-hours emergency care instructions/telephone information is made available to clients.	1				
B. Sufficient health care personnel provide timely, appropriate health care services.[12]					
1. Appropriate licensed personnel handle emergent, urgent, and medical advice telephone calls.	1				
2. Telephone answering machine, voice mail system, or answering service is used whenever office staff does not directly answer phone calls.	1				
3. Telephone system, answering service, recorded telephone information, and recording device are periodically checked and updated at the time of personnel change or schedule change.	1				
Subtotal:					

Comments: Write comments for all zero (0) scores.

[11] 22 CCR §56500, §53855, 10 CCR §1300.57.1
[12] 22 CCR §53855, 10 CCR §1300.67.1, §1300.80

Criteria	Facility Reviewer Guidelines
Office Management Survey Criteria	
C. Readily available health care services shall be provided.	There is a process/system in place on-site that provides clients with timely access to appointments for routine care, urgent care, prenatal care, initial and periodic pediatric health assessments/immunizations, initial health assessments, and emergency care. Missed and/or canceled appointments, contact attempts, and results of referral(s) are documented in the client's medical record.
D. There is 24-hour access to interpreter services for limited-English proficient (LEP) clients.	All Provider sites provide 24-hour interpreter services for all clients either through telephone language services or interpreters on-site. Any site personnel used as interpreters have been assessed for their medical interpretation performance skills/capabilities. A family member or friend may be used as an interpreter if requested by the LEP individual after being informed of their right to use free interpreter services. A client's request for or refusal of language/interpreter services must be documented in the client's medical record. **Note:** Assessment of interpreter skills may include written or oral assessment of bilingual skills, documentation of the number of years of employment as an interpreter or translator, documentation of successful completion of a specific type of interpreter training programs (medical, legal, court, semi-technical, etc.), and/or other reasonable alternative documentation of interpreter capability. List in the comment section any site personnel with language proficiency other than English and the language(s) in which said personnel are proficient.

Office Management Survey Criteria	Wt.	Yes	No	N/A	Site Score
C. Readily available health care services are provided.[13]					
1. An appointment system is available.	1				
2. Clients are notified of scheduled routine and/or preventive screening appointments.	2				
3. There is a system in place and written procedures for Immunizations, Infection Control.	2				
4. There is a system in place to follow up missed and cancelled appointments.	2				
5. There is a system in place for monitoring periodicity, tracking of referrals and follow-up appointments.	2				
D. There is 24-hour access to interpreter services for limited-English proficient clients.[14]					
Interpreter services are made available to all LEP clients.	1				
Subtotal:					

Comments: Write comments for all zero (0) scores.

[13] 22 CCR §56000
[14] 22 CCR §53855, Civil Rights Act of 1964, Title VI (§601), Hill-Burton Act, Health and Safety Code §1259

Criteria	Facility Reviewer Guidelines
E. Referral/ consultative services are handled according to established site-specific procedures.	There is a process/system in place on-site to make timely referrals both internally and externally, track outstanding referrals, complete review reports, provide follow-up care, and file reports in medical records. Referral resource information is readily available on-site for use by Provider and site personnel. Systems will vary per site. However, personnel must effectively utilize established site specific procedures to ensure timely provision of referral/consultative services and follow-up care. Current Medi-Cal Provider Manuals, CHDP Health Assessment Guidelines, CHDP Provider Manual, CHDP Provider Information Notices, or other manuals are available for reference. Give points if the Provider has internet access and uses the Medi-Cal website.

Office Management Survey Criteria	Wt.	Yes	No	N/A	Site Score
E. Referral/consultative services are handled according to established site-specific procedures.[15]					
Office systems and written procedures are effective in:					
1. Tracking referrals, consultant reports, and diagnostic test results, including lab procedures referred to other Providers, immunizations not performed on-site.	2				
2. Providing timely review/follow-up of referral consultation reports and diagnostic tests by physician(s).	2				
3. Using and maintaining CHDP Provider Manual, CHDP Health Assessment Guidelines, CHDP Provider Information Notices.	1				
Subtotal:					

Comments: Write comments for all zero (0) scores.

[15] 10 CCR §1300.67, 22 CCR §56500

Criteria	Facility Reviewer Guidelines
Office Management Survey Criteria	
F. Medical records are readily retrievable for the Provider at each scheduled client encounter.	A system is in place and utilized by site personnel to effectively coordinate the availability of medical records, including outpatient, inpatient, referral services, and significant telephone consultations, for client encounters. Refer to the CHDP Medical Record Review Tool (DHS 4492) for more information.
G. Confidentiality of personal medical information is protected according to state and federal guidelines.	**Privacy:** Clients have the right to privacy for dressing/undressing, physical examination, and medical consultation. Practices are in place to safeguard client privacy. Because dressing areas and examination room configurations vary greatly, reviewers will make site-specific determinations. **Confidentiality:** Personnel follow site office policy/procedures for maintaining confidentiality of individual patient information. Clients or their conditions are not discussed in front of other clients or visitors. Individual client information is not displayed or left unattended in reception and/or client flow areas. **Electronic records:** If an electronic record-keeping system is used, procedures must be in place to ensure client confidentiality, prevent unauthorized access, authenticate electronic signatures, and maintain computer systems. Security protection must include an off-site backup storage system, an image mechanism with the ability to copy documents, a mechanism to ensure recorded input unalterable, and file recovery procedures. Confidentiality protection may also include use of encryption, detailed user access controls, transaction logs, and blinded files. **Record release:** Medical records cannot be released without written, signed consent from the client or client's representative, identifying the specific medical information to be released. The release terms, such as to whom records are released and for what purposes, should also be described. This does not prevent release of statistical or summary data, or exchange of individual identifiable medical information between individuals or institutions providing care, fiscal intermediaries, research entities, and state or local official agencies. **Retention:** Medical records are retained until seven years after children reach age 21, or according to current applicable California statutes. **Purging and destruction:** Written policy/procedure is present that defines how these processes occur.

Office Management Survey Criteria	Wt.	Yes	No	N/A	Site Score
F. Medical records are readily retrievable for the Provider at each scheduled client encounter.[16]					
1. Medical records are readily retrievable for scheduled client encounters. Refer to the CHDP Medical Record Review Tool (DHS 4492).	1				
G. Confidentiality of personal medical information is protected according to state and federal guidelines.[17]					
1. Exam rooms, dressing gowns are available to safeguard clients' right to privacy.	1				
2. Site staff follows procedures to maintain the confidentiality of personal client information.	1				
3. Medical records are retained until seven years after children reach 21, or according to current applicable California statutes.	1				
4. Site-specific written procedures are followed for medical record purging/destruction.	1				
Subtotal:					

Comments: Write comments for all zero (0) scores.

Section Total:					

[16] 10 CCR §1300.80
[17] 10 CCR §1300.80, 22 CCR §51009, Confidentiality of Medical Information Act (Civil Code §56.10)

Criteria	Facility Reviewer Guidelines
Pharmaceutical Services Survey Criteria	
A. Drugs and medication supplies are securely stored to prevent unauthorized access.	**Medication supplies and storage:** All medications, hypodermic needles/syringes, and prescription pads are securely stored in a cabinet with locking capability.

4. Clinical Services

Pharmaceutical Services Survey Criteria	Wt.	Yes	No	N/A	Site Score
A. Drugs and medication supplies are securely stored to prevent unauthorized access.[18]					
All prescriptions, controlled drugs, sample and over-the-counter drugs, hypodermic needles/syringes, and prescription pads are securely stored in a lockable space (cabinet or room) within the office/clinic.	1				
Subtotal:					

Comments: Write comments for all zero (0) scores.

[18] 22 CCR §75037, Business and Professional Code §2018, §4051.3, CFR §1301.75

Criteria	Facility Reviewer Guidelines
Pharmaceutical Services Survey Criteria **B. Immunizations are administered and stored according to state/federal standards.**	**Vaccines for Children (VFC) Provider/Participant:** Business entity or examiner must participate in the VFC Program. **Storage:** Medications must be kept separate from food, lab specimens, cleaning supplies, and other items that may potentially cause contamination. Drugs must be stored under appropriate conditions of temperature, humidity, and light so that the identity, strength, quality, and purity of the drug product is not affected (21 CFR, Section 211.142). A drug is considered "adulterated" if it has been held under unsanitary conditions that may have been contaminated with filth or rendered injurious to health (21 USC, Section 351). **Drug preparation:** A drug or device shall be deemed to be adulterated of it consists in whole or in part of any filthy, putrid, or decomposed substance, or if it has been prepared, packed, or held under unsanitary conditions (21 USC, section 351). **Immunobiologics:** Failure to adhere to recommended specifications for storage and handling immunobiologics can make their products impotent. Vaccines must be refrigerated immediately and stored according to specific instructions on the package insert for each vaccine. Vaccines, such as MMR, DTP, DTaP, DT, Td, Hep A, Hep B, Enhanced Inactivated Polio (E-IPV), and Pneumococcal, must be kept in a refrigerator maintained at 2^{o} to 8^{o}C or 35^{o} to 46^{o}F. Oral polio vaccine (OPV) and varicella vaccines are stored in the freezer at -15^{o}C or 5^{o}F, or lower. If vaccines are in solid state and contain ice crystals on the outside of vial, reviewers shall consider stored vaccines appropriately frozen. MMR and varicella must be protected from light at all times and kept cold. Vaccines should not be stored in the doors of refrigerator or freezer. Diluent does not need refrigeration if vaccine is administered right after diluent is added. Refrigerator and freezer temperatures must be checked at least twice each day. **Vaccine Immunization Statements (VIS):** Since 1994, the National Childhood Vaccine Injury Act, Section 2126 of the Public Health Services Act, mandates that parents/guardians or adult clients be informed before vaccinations are administered. Health care Providers must give a copy of the most recent VIS, in appropriate threshold languages, to clients prior to each vaccination dose of Diphtheria/Tetanus/Pertussis (DTaP), Hepatitis A, Hepatitis B, Hib, Influenza, Measles, Mumps, Rubella (MMR), Pneumococcal Polysaccharide, Pneumoccocal Conjugage, Polio, Tetanus/Diphtheria (Td), or Varicella. The date the VIS was given and the publication date of the VIS must be documented in the client's medical record. Reviewers shall interview personnel about standard practices on-site regarding VIS distribution. **Note:** The California DHS Immunization Branch recommends checking temperatures twice a day, first thing in the morning and last thing at night. The most current VISs are available from state and local health departments or can be downloaded from the CDC website at **www.cdc.gov/nip/publications/VIS** or by calling the CDC Immunization Hotline at 800-232-2522.

Pharmaceutical Services Survey Criteria	Wt.	Yes	No	N/A	Site Score
B. Immunizations are administered and stored according to state/federal standards.[19] The site/Provider:	CE				
1. Is a VFC Provider/participant.					
2. Uses the screening procedure or acceptable alternate procedure for VFC eligibility.					
3. Implements a routine written procedure to check and dispose of expired immunizations.					
4. Prepares immunizations in a clean area.					
5. Has a supply of safety needles, gloves, syringes (3 cc and tuberculin) and appropriate disposable needles.					
6. Needles and syringes are stored securely.					
7. Gives the most recent VIS statements, available in threshold languages, prior to the administration of every dose of vaccine, and records the date.					
8. Disposes of safety needles in puncture resistant container which is color coded/leak proof/labeled biohazard.					
9. Immunizations are stored with proper labels in a secure, designated area.					
10. Immunizations are available and administered.					
a. Polio (IPV)					
b. DTaP/DT/Td					
c. MMR					
d. Hib					
e. Hep B					
f. Hep A					
g. Varicella					
h. Pneumococcal Conjugate					
i. Pneumococcal Polysaccharide					
j. _____					
11. The site has a plan for vaccine protection in case of power outage.					
12. Written log(s) document temperature checks twice a day of immunobiologics refrigerator and freezer.					
13. Refrigerator thermometer temperature is 35°–46° Fahrenheit or 2°–8° Centigrade (at time of site visit).					
14. Freezer thermometer temperature is 5° Fahrenheit or -15° Centigrade or lower (at time of site visit).					
15. Mantoux TB antigen is available for administration.					
Comments: Write comments for all zero (0) scores. **Subtotal:**					
Section Total:					

[19] "Drugs/Immunobiologics stored according to state/federal standards." 22 CCR §75037, 21 USC §351, 21 CFR §211.137

Criteria	Facility Reviewer Guidelines
Laboratory Survey Criteria	
A. Site is compliant with Clinical Laboratory Improvement Amendments (CLIA) of 1988 regulations.	**Clinical Laboratory Improvement Amendments (CLIA) of 1988 certificates:** All clinics/offices performing laboratory testing for assessment of human health or diagnosis, prevention, or treatment of disease must have a current, unrevoked, unsuspended site-specific CLIA certificate, or evidence of renewal. All places that perform tests or examinations on human biological specimens derived from the human body are, by definition, "laboratories" under state and federal law. Therefore, laboratories may exist at locations such as nurses' stations within hospitals, clinics, surgical centers, physician offices, and health fairs. A copy of an original, site-specific certificate or renewal receipt is acceptable. CLIA certificates on-site may include one/more of the following: 1. **Certificate of Waiver:** Site is able to perform only exempt waived tests. 2. **Certificate for Provider-Performed Microscopy (PPM):** Physicians, dentists, or mid-level practitioners are able to perform PPM procedures and waived tests. 3. **Certificate of Registration:** Allows moderate and/or high complexity lab testing to be conducted until compliance with CLIA regulations is determined by survey. 4. **Certificate of Compliance:** Lab has been surveyed and found in compliance with all applicable CLIA requirements. 5. **Certificate of Accreditation:** Lab is accredited by an accreditation organization approved by the Centers for Medicare and Medicaid Services formerly, Health Care Financing Administration (HCFA). **Waived tests:** Sites that perform only waived tests must obtain a CLIA Certificate of Waiver. While there are no specific CLIA regulations that apply to the performance of waived tests, following the test manufacturer's instructions is required. Laboratories with certificates of waiver may not be routinely inspected. However, they may be inspected as part of complaint investigations and on a random basis to determine whether only waived tests are being performed. **Moderate and high complexity tests:** All tests not listed as waived are divided into one of two categories, moderate complexity or high complexity, based on the complexity of the testing procedure. For these categories the CLIA regulations list specific requirements for laboratory proficiency testing, client test management, quality control, quality assurance, personnel, and inspections. **Trained and certified laboratory personnel:** Prior to testing biological specimens, all personnel must be appropriately certified/licensed and have training for the type and complexity of the services offered, and have demonstrated that they can perform all testing operations reliably to provide and report accurate results. **Note:** The current listing of waived tests may be obtained at: **www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfClia/testswaived.cfm**. For questions regarding CLIA certification, laboratory licensing, and personnel, call California DHS Laboratory Field Services at 510-873-6328.

Laboratory Survey Criteria	Wt.	Yes	No	N/A	Site Score
A. Site is compliant with CLIA regulations.[20]					
1. Laboratory test procedures are performed according to current site-specific CLIA certificate and all specialized medical equipment is maintained according to equipment manufacturer's guidelines, including annual calibration.	1				
2. Appropriately certified and/or trained staff performs clinical lab testing procedures, including urine dipstick, hemoglobin/hematocrit specific to CLIA certificate.	1				
3. Lab supplies/equipment are maintained clean and inaccessible to unauthorized persons.	1				
4. Site has a procedure to check expiration date and a method to dispose of expired lab test supplies.	1				
Subtotal:					

Comments: Write comments for all zero (0) scores.

Section Total:					

[20] 17 CCR §1050, 22 CCR §51137.2, §51211.2, Business and Professional Code §1220, 42 USC 263a, Public Law 100.578

Criteria	Facility Reviewer Guidelines
Preventive Services Survey Criteria **A. Pediatric preventive health care services and health appraisal examinations are provided on a periodic basis for the detection of asymptomatic diseases.**	Examination equipment appropriate for infants, children, and adolescents is available on-site and maintained according to manufacturer's guidelines: **Examination table:** "Good repair" means clean and well maintained in proper working order. Sites must use a protective barrier to cover exam surface that is changed between patient contact. **Basic equipment:** Exam gown sizes are appropriate to population served on-site. Stethoscopes and sphygmomanometers and various size cuffs are available in child, adult, and obese/thigh sizes. Ophthalmoscopes and otocopes are present with working lights. Pediatric ear speculums are available. **Scales:** Infant scales must be marked and accurate to increments of 1 ounce or less, and have a capacity of at least 35 pounds. Standing floor scales must be marked and accurate to increments of 1/4 pound or less, and have a capacity of at least 300 pounds. Balance beam or electronic scales are appropriate for clinic use. Balance scales must have an adjustment mechanism and zeroing weight to enable routine balancing at zero. Electronic or digital scales must have automatic zeroing and lock in weight features. Spring balance scales (e.g., bathroom scales) are unsatisfactory for clinical use because, over time, the spring counter balance mechanism loses its accuracy. All scales must be routinely maintained according to manufacturer's guidelines and/or calibrated by a professional vendor at least annually. Use of a standardized weight is satisfactory only for routine scale maintenance, but does not satisfy the need for calibration accuracy through the full range of weight measured by the scale. There must be documentation of professional calibration completed within the last 12 months of the site audit if recommended by the product manufacturer or if the manufacturer's guidelines are not available on-site. **Measuring devices:** Equipment for measuring stature (length/height) and head circumference must include: 1. Rigid 90^{o} right angle headboard block that is perpendicular to the recumbent measurement surface or vertical to the wall-mounted standing measurement surface. 2. Flat, paper, or plastic nonstretchable tape or yardstick marked to one-eighth (1/8 or 1 mm) or less attached to a firm, flat surface. The "0" of the tape must be exactly at the base of the headboard for recumbent measurement or exactly at foot level for standing measurement. 3. Moveable, nonflexible footboard at 90^{o} right angle perpendicular to the recumbent measurement surface, or a flat floor surface for standing. 4. Nonstretchable tape measuring devise marked to one-eighth (1/8 or 1 mm) or less for measuring head circumference. **Vision screening:** Sites must have both the Snellen and an illiterate eye chart, such as the "E" eye chart or illiterate kindergarten chart or the Allen Test. "Heel" lines must be aligned with center of eye chart at a 20/40-feet or equivalent (e.g., 10/20) line. Eye charts should be in a location with adequate lighting and at height(s) appropriate to use. Disposable eye "occluders," such as Dixie cups or tongue blades with back-to-back stickers, are acceptable. Nondisposable occluders must be cleaned between clients. **Hearing screening:** Sites must have a state-approved, calibrated audiometer. A quiet area to administer the test must be available. **Note:** Although client population varies from site to site, the screening equipment listed in this section is the standard equipment most often used in performing a physical health screening examination for children and adults.

5. Pediatric Preventive Services

Preventive Services Survey Criteria	Wt.	Yes	No	N/A	Site Score
A. Pediatric preventive health care services and health appraisal examinations are provided on a periodic basis for the detection of asymptomatic diseases.[21]					
Examination equipment appropriate for infants, children, and adolescents is available on-site and maintained according to manufacturer's guidelines:	CE				
1. Exam tables, paper for tables, and lights are in good repair.					
2. Stethoscope and sphygmomanometer and various size cuffs: child, adult, and obese/thigh with appropriate staff trained to use the equipment.					
3. Thermometers: oral and/or tympanic, and rectal and appropriate staff trained to use these thermometers.					
4. Scales: adult balance beam and infant scales.					
5. Measuring devices for stature (height/length) measurement and head circumference measurement.					
6. Basic exam equipment: percussion hammer, tongue blades, client gowns.					
7. Vision screening charts (Snellen and illiterate or equivalent) and occluder for vision testing.					
8. Ophthalmoscope with working light.					
9. Otoscope with working light and adult and pediatric ear speculums.					
10. State-approved, calibrated audiometer, in a quiet area, with documented staff training for use.					
Subtotal:					

Comments: Write comments for all zero (0) scores.

[21] 10 CCR §1300.67, 22 CCR §53851, §56210

Criteria	Facility Reviewer Guidelines
Preventive Services Survey Criteria	
B. Health education services are available to clients.	**Health education services:** These may include Provider or community sponsored services such as individual instruction, family counseling, group classes, and/or other health educational program. **Health education materials:** These may include written information, audio and/or videotapes, computerized programs, and visual presentation aids. General topics for health educational materials may include immunizations, pregnancy, injury prevention, smoking cessation, dental health, nutrition, physical activity, STD/HIV prevention, family planning, asthma, hypertension, diabetes, etc. Materials may be located in an accessible area on-site such as exam or waiting room or provided by clinic staff to clients upon request. CHDP-provided health education materials are evident. **Threshold languages:** Informing materials and interpreter services must be provided in identified threshold and concentration standard languages. **Note:** Threshold languages are the primary languages spoken by Limited English Proficient (LEP) population groups residing in a county. A numeric threshold of 3,000 eligible LEP Medi-Cal beneficiaries, or a concentration standard of 1,000 residing in a single ZIP code or 1,500 in two contiguous ZIP codes establishes the threshold languages identified by the Department of Health Services for each county.

Health Education Survey Criteria	Wt.	Yes	No	N/A	Site Score
B. Health education services are available to clients.[22]					
Health education materials and resource information are:					
1. Readily accessible to clients on-site or are made available upon request.	2				
2. Applicable to the practice and population served on-site and include CHDP-provided health education materials.	2				
3. Available in threshold languages, including sign language, identified for county/area of site location.	2				
4. Inclusive of a resource list for services/programs such as Healthy Families, WIC, dental and mental health.	2				
Subtotal:					

Comments: Write comments for all zero (0) scores.

Section Total:					

[22] 22 CCR §53851

Criteria	Facility Reviewer Guidelines
Infection Control Survey Criteria	
A. Infection control procedures for standard/universal precautions are followed.	**Infection control:** Procedures must be present on preventing infection transmissions among clients as well as personnel. **Universal precautions:** Site personnel practices the approach to infection control whereby all human blood and body fluids are treated as potentially infectious materials for HIV, HBV, or HCV, and other bloodborne pathogens. **Hand-washing facilities:** There must be an adequate supply of running potable water, soap, and single-use towels or hot-drying machines. Acceptable hand-washing facilities may be available in the exam room and/or utility room. If facilities are not available in the immediate client exam areas, staff must demonstrate methods used on-site to provide infection control "barriers" to prevent contamination of door handles, surfaces, etc. until hand-washing can be performed. Although foot-operated pedals or 4–6 inch wing-type faucet handles may be optimal in treatment/exam room areas, do not deduct points if not on-site. **Antiseptic hand cleaner:** For general client care, a plain, nonantimicrobial soap is appropriate in any convenient form, such as bar, leaflets, liquid, or powder (Association for Professionals in Infection Control and Epidemiology, Inc., 1995). Hand antisepsis, by use of soap or detergent products containing antimicrobrial agents or alcohol-based antiseptic handrubs, is recommended before the performance of invasive procedures, when persistent antimicrobial activity on the hands is desired, or to reduce numbers of resident skin flora in addition to transient microorganisms. Hand wash products must be stored/dispensed to prevent contamination or infection. **Decontamination:** "Contamination" means the presence or reasonably anticipated presence of blood or OPIM on an item or surface. Decontamination is the use of appropriate physical or chemical means to remove, inactivate, or destroy bloodborne pathogens on a surface or item so that they are no longer capable of transmitting infectious particles and the surface or item is rendered safe for handling, use, or disposal. Sites must have an established blood/body fluid spill procedure. Staff is able to identify site-specific process and procedures for handling decontamination of blood/body fluid spills, the frequency of routine cleaning of surfaces and equipment, the appropriate disinfectant used, and the responsible person(s). Procedures and practices on-site assure prompt decontamination of work surfaces/coverings, equipment, bins/pails, and trash receptacles after contact with blood or any OPIM. Written "housekeeping" schedules are established and followed for regular routine daily cleaning of work surface/coverings, equipment, bins/pails, and trash receptacles. **Disinfectant products:** Any product(s) used for decontamination must have a current approval status by the Environmental Protection Agency (EPA). Effectiveness in killing HIV/HBV/HCV must be stated on the manufacturer's product label. Some products can be used as both a sterilent and/or a disinfectant depending on reconstitution method and application time and process. When used for decontamination, product must be reconstituted and used according to manufacturer's guidelines for "decontamination." **Note:** The principles of infection control are established to minimize the risk of disease transmission to clients, Providers, and the Provider's employees. The purpose of hand washing is to remove dirt, organic material, and transient microorganisms. Both plain and antiseptic hand wash products can become contaminated or support the groWt.h of microorganisms if not stored or dispensed properly. Reviewers should note whether hand wash products are maintained appropriately to prevent contamination. **Note:** If a 10 percent bleach solution is used, the solution must be changed/reconstituted every 24 hours due to instability of each once mixed with water. Current EPA lists/information can be obtained from the National Antimicrobial Information Network (NAIN) at 703-308-0127 or at: **www.epa.gov/oppad001**.

6. Infection Control

Infection Control Survey Criteria	Wt.	Yes	No	N/A	Site Score
A. Infection control procedures for standard/universal precautions are followed.[23]					
1. Antiseptic hand cleaner and running water are available in exam and/or treatment areas for hand washing.	1				
2. A waste disposal container is available in exam rooms, procedure/treatment rooms and restrooms.	1				
3. Site has procedure for effectively isolating infectious clients with potential communicable conditions.	1				
4. Personal Protective Equipment is readily available for staff use.	1				
5. Needlestick safety precautions are practiced on-site.	1				
6. All sharp injury incidents are documented.	1				
7. Equipment and work surfaces are appropriately cleaned and decontaminated after contact with blood or OPIM.	1				
8. Routine cleaning and decontamination of equipment/work surfaces is completed according to site-specific written schedule.	1				
9. Disinfectant solutions used on-site are approved by the EPA, effective in killing HIV/HBV/HCV, and used according to product label for desired effect.	1				
Subtotal:					

Comments: Write comments for all zero (0) scores.

[23] Department of Labor, OSHA, Federal Register 1989, §54:23042, *Pediatrics,* Volume 105, No. 6, June 2000

Criteria	Facility Reviewer Guidelines
Infection Control Survey Criteria **B. Site is compliant with OSHA Bloodborne Pathogens and Regulated Waste laws/regulations.**	**Work practice and engineering controls are used on-site to decrease exposure to bloodborne pathogens.** **Personal Protective Equipment (PPE):** The minimal PPE (specialized clothing/equipment for protection against bloodborne pathogen hazards) available to staff on-site must include water repelling gloves, clothing barrier (gown, sheets), eye protection (goggles), and respiratory infection protection (mask). The availability of other PPE on-site is specific to the practice and the types of procedures performed. General work clothes (uniforms, cloth lab coats) are not considered PPE because they permit liquid to soak through, but is appropriate only if blood/OPIM does not penetrate through employee's work clothes, undergarments, skin, eyes, mouth, or other mucous membranes under **normal** conditions of use. **Needlestick safety:** Needles are not bent, recapped, or removed from a syringe unless a one-handed technique is used. Needleless systems, needle devices, and nonneedle sharps are used unless Cal/OSHA exemptions are met (8 CCR, Section 5193). Any device capable of cutting or piercing (e.g., hypodermic needles, syringes, needleless devices, blades, broken glass, slides, vials) must be placed in a closable, puncture-resistant, labeled container that is leak-proof on the sides and bottom. A variety of products from cardboard to plastics is acceptable as long as the requirements for a sharps container is met. Contaminated sharps are discarded immediately. Containers are located close to the immediate area where sharps are used, and are inaccessible to unauthorized persons. Security of portable containers in patient care areas is maintained at all times. Containers are not overfilled past manufacturer's designated fill line or more than ¾ full. Supply of containers on hand is adequate to ensure routine change-out when filled. **Sharps injury documentation:** Name, date/time/description of exposure incident, sharp type/brand, follow-up care is documented within 14 days of injury incident. **Site appropriately contains, labels, and stores all regulated/medical wastes generated on-site.** **Blood and other potentially infectious materials (OPIM):** OPIM are all human body fluids, any unfixed tissue or organ (other than intact skin) from a human (living or dead), and HIV or HBV-containing blood, cells, tissue, organs, cultures, medium, or solutions. Containers must be closable, leak proof, and labeled and/or color-coded. Double bagging is required only if leakage is possible. **Labels:** A warning label must be affixed to red-bagged regulated wastes, sharps containers, refrigerators and freezers containing blood or OPIM, or any containers used to store, transport, or ship blood or OPIM, and contaminated laundry and/or equipment to be stored or shipped. The international "BIOHAZARDOUS WASTE" label, predominantly fluorescent orange or red-orange with contrasting lettering/symbols, must be an integral part of the container or closely affixed to prevent loss or unintentional removal. Sharps containers must be labeled with the words "sharps waste" or with the international biohazard symbol and the word "BIOHAZARD." Individual containers of blood or OPIM are exempted from warning labels if placed in an appropriately labeled secondary container during storage, transport, shipment, or disposal. Facilities may use alternative marking or color coding to label contaminated laundry or specimen containers that remain in the facility if handled using Universal Precautions and the alternative marking permits all employees to recognize that the container requires compliance with Universal Precautions. An international Biohazardous Waste warning label and/or red color-coding would be required if the laundry or specimen leaves the facility. **Contaminated laundry:** Laundry that has been soiled with blood or OPIM or may contain contaminated sharps. If disposable PPE is not used, other options acceptable by Cal/OSHA is use of a commercial Laundromat, a contracted laundry service, or a washer and dryer on-site. Decontaminating and laundering of protective clothing is by washing and drying garments according to manufacturer's instructions. **Regulated waste storage:** Although covered waste containers are optimal in all patient care and restroom areas, only infectious wastes container(s) must be covered. Biohazardous and medical wastes require special handling as regulated by Chapter 6.1 of the Health and Safety Code (California Medical Waste Management Act). "Biohazardous wastes" include laboratory wastes, human specimens/tissues, and blood/contaminated materials "known" to be infected with highly communicable diseases for human and/or require isolation. "Medical wastes" include liquid/semi-liquid blood or OPIM, items caked with dry blood or OPIM and capable of releasing these materials during handling, and contaminated sharps. All regulated waste materials must be contained separately from other waste at the point of origin in the producing facility, placed in red biohazardous bags with Biohazard label, and stored in a closed container that is not accessible to unauthorized persons. If stored outside of the office, a lock secures the entry door, gate, or receptacle lid, and posted warning sign(s) in English and Spanish are visible for a distance of 25 feet. The wording shall state "CAUTION—BIOHAZARDOUS WASTE STORAGE AREA—UNAUTHORIZED PERSONS KEEP OUT" and "CUIDADO—ZONA DE RESIDUOS—BIOLÓGICOS PELIGROSOS—PROHIBIDA LA ENTRADA A PERSONAS NO AUTORIZADAS." Signs permitted prior to the passage of the Medical Waste Act, Infectious Waste, are permitted for the "life" of the sign. **Medical waste disposal:** All medical waste must be hauled to a permitted off-site medical waste treatment facility, a transfer station, or another registered generator for the consolidation. Hauling must be by a registered hazardous waste transporter or by a person with an approved limited-quantity hauling exemption granted by the California DHS Waste Management Division. Generators of medical waste must maintain a tracking document that includes the name of person transporting, number of containers, type of medical wastes, and date of waste transportation. The limited-quantity hauling exemption is valid for a period of one year and must be renewed annually. When hauling medical wastes, the transporter must have the exemption form in the transporting vehicle. If medical waste is not hauled, the site must use another legally approved method of disposal as described in law. **Note:** Contaminated wastes include materials soiled with blood during the course of their use but are not within the scope of regulated wastes. Contaminated waste items (e.g., dental drapes, band aids, sanitary napkins) need not be disposed as regulated waste in labeled red bags, but can be discarded as solid waste in regular trash receptacles.

Infection Control Survey Criteria	Wt.	Yes	No	N/A	Site Score
B. Site is compliant with OSHA Bloodborne Pathogens and Regulated Waste laws/regulations.[24]					
1. Work practice and engineering controls are used on-site to decrease exposure to bloodborne pathogens.					
a. Personal protective equipment is readily available for staff use.	1				
b. Needlestick safety precautions are practiced on-site.	1				
c. All sharp injury incidents are documented.	1				
2. Site appropriately contains, labels, and stores all regulated/medical wastes generated on-site.					
a. Blood, other potentially infectious materials (specimens) and regulated wastes (sharps/biohazardous nonsharps) are placed in appropriate ***leak proof***, ***labeled*** containers for collection, handling, processing, storage, transport, or shipping.	1				
b. Biohazardous (nonsharp) wastes are contained separate from other trash/waste.	1				
c. Contaminated laundry is laundered at the workplace or at a commercial laundry.	1				
d. Storage areas for regulated medical wastes are maintained, secure, and only accessible to authorized persons.	1				
e. Transportation of regulated medical wastes is ***only*** by a registered hazardous waste hauler or by a person with an approved limited-quantity exemption.	1				
Subtotal:					

Comments: Write comments for all zero (0) scores.

Section Total:					

Special Acknowledgement: This tool was adapted from a draft of the Medi-Cal Managed Care Division's Site Survey Tool, Draft 12.

[24] 8 CCR §5193, Cal OSHA Health Care Worker Needlestick Prevention Act (1999), California Health and Safety Code, §117600–118360 (California Medical Waste Management Act, 1997), 29 CFR §1910.30